Infection/Disease Control

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) CONTROL PROGRAM

1. **Purpose**: To provide for Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) screening and treatment of residents/employees in order that Florida State Hospital may:
   
   a. provide appropriate counseling and testing services for HIV/AIDS infection;
   
   b. establish infection control procedures to protect employees and residents;
   
   c. provide safe and appropriate levels of psychiatric and medical care for residents with HIV/AIDS infection;
   
   d. establish reporting requirements; and
   
   e. maintain confidentiality.

2. **Scope**: This operating procedure will apply to all areas of Florida State Hospital.

3. **Training Requirement**: All employees will be trained on this operating procedure upon hire at Florida State Hospital during New Employee Education, and by their supervisor each time the operating procedure is revised.

4. **References**:
   
   a. Florida Administrative Code, Chapter 64D-3, Control of Communicable Diseases and Conditions Which May Significantly Affect Public Health.
   
   b. Florida Administrative Code, Chapter 64D-2, Human Immunodeficiency Virus (HIV).
   
   c. Chapter 384, Florida Statutes, Sexually Transmitted Diseases.
   
   
   e. Florida Department of Children and Families Operating Procedure 155-4, HIV/AIDS Screening & Treatment in State Mental Health Treatment Facilities.
   


i. Centers for Disease Control, Guidelines for Isolation Precautions in Hospitals.

j. Florida State Hospital Operating Procedure 153-15, Preventive Infection Control Program.

k. Centers for Disease Control, Guidelines for the Use of Antiretroviral Agents in HIV -1-Infected Adults and Adolescents.


m. Florida Department of Health Information Security Policies, Protocols and Procedures #1-#18.5.


o. Florida State Hospital Operating Procedure 153-1, Bloodborne Pathogens Exposure Control Plan.


5. **Definitions:**

a. **“AIDS”**--Acquired Immune Deficiency Syndrome, as defined by the Centers for Disease Control.

b. **“HIV”**--Human Immunodeficiency Virus identified as the causative agent of AIDS.

c. **“HIV Infection”**--Infected with HIV, as evidenced by a confirmed laboratory test for antibodies to HIV.

d. **“Pre-test Counseling”**--A counseling service provided to the individual before a blood specimen is collected, which addresses the nature of the test, its benefits, limitations; measures for the prevention of exposure to, and transmission of HIV; confidentiality measures, risk reduction advice, and the procedure for providing test results.

e. **“Post-test Counseling”**--A counseling service provided to the individual which addresses the interpretation of test results and, if necessary, the need for and access to medical evaluation, or referral for other services; risk assessment and risk reduction advice relevant to the individual’s test results.

f. **HIV Counselor**--A staff member who has completed the required Department of Health curriculum and is certified to provide Pre and Post Test HIV/AIDS Counseling.

g. **Informed Consent for HIV/AIDS Testing**--Informed consent consists of:
(1) pre and post test counseling by an HIV Counselor,

(2) informing person to be tested of the confidential treatment of information obtained and test results

(3) informing person tested that a positive HIV/AIDS test result will be reported to the Department of Health as required by law,

(4) person to be tested will be informed of the two (2) types of testing, confidential and anonymous,

(5) if the person agrees to be tested, a signature is required on the consent form, Consent for Confidential Human Immunodeficiency Virus (HIV) Test (Department of Health Form 1818, page 1) (Attachment 1), and must be witnessed.

6. General:

a. A transmissible virus, HIV is the underlying cause of AIDS. Its transmission requires: intimate sexual contact via vaginal or rectal intercourse or oral sex; parenteral spread as among intravenous drug abusers, or administration of infected blood or blood products; and perinatally from infected mothers to their newborn. There is no evidence to suggest that spread occurs through the air or by casual contact. HIV/AIDS is predominantly a semen and blood transmitted disease.

b. There is, at present, no vaccine to prevent infection nor curative treatment for HIV/AIDS, although advances have been made in improving the quality and length of lives of HIV/AIDS persons through the development of antiviral medication and improved testing and monitoring technology. Educating the general public of the risk behaviors for HIV/AIDS and the availability of testing (anonymous and confidential) is the best defense in helping to prevent the transmission of the HIV virus.

c. HIV infection causes immunosuppression and the risk for active tuberculosis is high in persons with tuberculosis infection and HIV infection. For this reason, persons who are tuberculin skin test negative and HIV sero-positive should be further evaluated for tuberculosis. Tuberculosis residents with HIV infection may not respond to standard tuberculosis therapy. (Reference: Florida State Hospital Operating Procedure 153-4, Tuberculosis Control Program.)

d. The following procedures are to be considered with the HIV/AIDS Control Program but require additional guidelines and are covered more specifically in the following Florida State Hospital Operating Procedures:

   (1) Florida State Hospital Operating Procedure 153-33, Sexually Transmitted Disease Control Program.

   (2) Florida State Hospital Operating Procedure 150-43, Family Planning Services.

   (3) Florida State Hospital Operating Procedure 153-29, Hepatitis Control Program.

7. Procedure:

a. Policy on Counseling and Testing:

   (1) HIV Counseling Services are to be provided by staff who have completed specific training and are certified as HIV Counselors.
(2) Counseling shall comply with the Model Protocol on Counseling and Testing for County Health Departments and Registered Testing Programs (Attachment 2). Note: Florida State Hospital Laboratory is a registered testing site with the Florida Department of Health and only offers confidential testing.

(3) A risk assessment to HIV/AIDS and other sexually transmitted diseases will be completed on all admissions to Florida State Hospital. Upon completion of risk assessments, HIV Antibody testing and counseling will be offered to all residents on admission. Consent will be documented on Department of Health Form 1818 (page 1), Consent for Confidential Human Immunodeficiency Virus (HIV) Test (Attachment 1).

(4) Risk assessments for HIV/AIDS, sexually transmitted diseases (STD's) will be completed when indicated for:

(a) residents who request testing;

(b) residents/employees who have received a significant exposure to another person infected with HIV/AIDS; and

(c) residents with clinical symptoms of HIV/AIDS.

(5) Residents who have risk factors for HIV, show clinical symptoms of AIDS or acute HIV infection and refuse or are unable to grant informed consent will be evaluated by the Unit Recovery Team. Administrative procedures may be initiated to obtain authority from the legal guardian or courts to conduct the HIV antibody testing.

(6) Any female resident who is pregnant on admission or becomes pregnant will be counseled and offered an HIV test as required by Florida law (s.384.31). If the resident objects, Department of Health Form 3161 (Attachment 3), is to be completed and placed in the resident's medical record. The test should be offered on admission to Florida State Hospital if a previous test is unavailable and again at 28-32 weeks gestation.

(7) HIV Pre and Post Test Counseling is to be documented on Florida State Hospital Form 13, Immunization/Treatment Record--Communicable Diseases/Education Form, and in the progress notes. (Attachment 4, page 2).

(8) HIV Post Test counseling is to be completed as soon as possible after the Unit receives the test results for residents (Attachment 5). The results and counseling must be completed within five working days and documented in the medical record. If the resident's mental or physical condition is unstable and counseling is delayed, documentation should reflect the rationale for the delay in the progress notes.

b. Confidentiality of Test Results:

(1) The results of HIV antibody tests are confidential and may not be publicly disclosed except with the resident's/employee's written permission or as otherwise provided in Chapter 384, Florida Statutes.

(2) Confidential medical information including HIV antibody test results may only be shared with employees of the department and its authorized representatives who are responsible for the custody, medical care and treatment of Department of Children and Families residential residents and who have a need to know such information.
(3) When a resident is transferred from Florida State Hospital to another facility, the medical records of residents including AIDS and HIV antibody positive data must be transferred in a sealed envelope marked confidential.

c. Penalties for Violation of Confidentiality: Employees of the Department of Children and Families who violate confidentiality of the medical records of an HIV antibody positive or AIDS resident/employee shall be subject to disciplinary action, including dismissal, and to criminal penalties as specified in Chapter 384, Florida Statutes.

d. Treatment:

(1) Florida State Hospital will provide, or arrange for, the provision of medical services needed by residents with AIDS or HIV infection. Unit medical personnel will refer residents with HIV/AIDS residents to the Medical Screening Clinic (Unit 31) for initial evaluation and follow-up as needed.

(2) Employees will be expected to observe Standard Precautions for all residents when performing procedures in which exposure to blood and body fluids is anticipated. Reference Florida State Hospital Operating Procedures 153-15, Preventive Infection Control Program, and 153-1, Bloodborne Pathogens Exposure Control Plan.

(3) Florida State Hospital will consider each sero-positive resident/employee on a case by case basis for recommendations to protect the employee from nosocomial pathogens and to protect high risk residents from pathogens possibly carried by other residents/employees.

(4) Residents with HIV/AIDS infection shall be provided services in the least restrictive setting. Most residents can participate fully in regular program activities. Others may require special supervision in a mainstream setting to minimize risk of exposure of other residents. In unusual situations, residents with aggressive behaviors of sexual activity, biting, or lack of control of body fluids may require temporary segregation until behavior improves.

e. Management of Resident/Employee Exposures:

   Note: Informed consent is required for HIV testing. There are a few exceptions which include court orders. Consult with Hospital Legal Services and Hospital Infection Control if a situation occurs which warrants testing and the person refuses to give consent.

   (1) When a secretion or excretion of an HIV infected individual enters the body of another individual by needle puncture wounds, scalpel cut, or any other type of skin perforation, or if there is contact with a mucous membrane surface, such as, the eye, nose or mouth of such an individual, or when there is entry of such material into open cuts, scratches, bites, hangnails or skin conditions, such as, dermatitis, and acne, the significant exposure criteria may have been met (see Attachment 6). A physician will evaluate the exposure and make recommendations for possible postexposure prophylaxis and lab monitoring. The National Clinicians’ Postexposure Prophylaxis Hotline (PEPline) may be called for assistance and recommendations.

   (2) When the exposure criteria is met, a Resident/Employee Possible Blood/Body Fluid Exposure Report, Form 180 (Attachment 7), is completed, and a HIV Antibody test is done as soon as possible after exposure and consent by the source of the exposure or receipt of a court order to perform the testing. If the source person is sero-positive and the exposed person is sero-negative, the test will be repeated at six (6) weeks, three (3) months, and six (6) months.
(3) Unit/Department Personnel will initiate the Resident/Employee Possible Blood/Body Fluid Exposure Report and will be responsible for ensuring that the resident receives the required follow-up testing at six (6) weeks, three (3) months, and six (6) months. During this follow-up period, especially during the first 6-12 weeks when most infected persons are expected to sero-convert, the exposed person should receive counseling and follow the precautions for prevention of HIV transmission.

   (a) Employee: Any employee, who in the performance of job duties, sustains a possible exposure to HIV, will report to the supervisor for immediate referral to the current Hospital Workers Compensation Provider.

   (b) Resident: Any resident who sustains a possible exposure to HIV will be immediately referred to the attending physician. Informed consent and pre-test counseling is required prior to testing. Post-test counseling will be provided, informing the resident of test results.

   (c) All Resident/Employee Possible Blood/Body Fluid Exposure Report Forms are to be completed and forwarded to the Office of Quality Assessment and Planning--Infection Control and Office Of Risk Management.

f. Education:

   (1) All resident/employee HIV/AIDS education will be provided in conjunction with Staff Development and Office of Quality Assessment and Planning--Infection Control, to ensure continuity and currency of the information provided. Additionally, members of the Hospital Nursing Management Team, under the section “Developing and Planning Program” of their Role and Function statement, will provide consultation on curriculum and delivery guidelines for resident education.

   (2) Staff Education:

      (a) New employees will complete the Infection Control Module of New Employee Training within 30 days of employment. This module includes the Bloodborne Pathogen Standard and HIV/AIDS. The HIV/AIDS training program will include:

         1. modes of transmission;

         2. infection control practices;

         3. clinical management;

         4. prevention of HIV and AIDS with emphasis on appropriate behavior and attitude change.

         5. Current Florida Law and its impact on testing, confidentiality of test results, and treatment of residents; and

         6. Protocols and procedures applicable to HIV counseling, testing, reporting and partner notification.

      (b) Updated training will be provided for staff if laws, regulations, treatments, or protocols change.
The operating procedure does not preclude the HIV/AIDS approved course requirement for continuing education as mandated by the legislature for licensed staff as part of biennial re-licensure.

(3) Resident Education:

(a) Unit Directors or designee will provide for resident education commensurate with the resident’s ability to understand/comprehend the subject matter and their potential/likelihood of exposure (Attachment 8).

(b) New Admission orientation will include information on Infection Control and each resident will be provided HIV/AIDS Education within 30 days following admission.

(c) Residents will be provided an update or refresher HIV/AIDS Education at least annually by unit personnel.

(d) AIDS Education will include:

1. basics of transmission of HIV infection;
2. prevention of transmission of HIV infection; and
3. methods to prevent transmission of HIV infection, i.e., safer sex, condoms, abstinence (Attachment 8).

(e) Resident HIV/AIDS education is to be documented on Form 13, Immunization/Treatment Record--Communicable Diseases/Education Form.

(g) Reporting Requirements:

(1) Laboratory requirements: The Hospital Clinical Laboratory will receive test results and will inform the Hospital Infection Control Nurse of positive results. In addition, the Laboratory will inform ward nurse or designee of resident results.

(2) Unit Reporting Requirements:

(a) Initial Reporting: Units will report to the Hospital Infection Control Nurse:

1. admission of any resident with a confirmed or suspected diagnosis of HIV/AIDS;
2. any laboratory report of a positive confirmed HIV/AIDS via the Unit Daily Infection Control Report by code;
3. incidents whereby any resident/employee sustains exposure to blood, secretions or excretions of a resident with a confirmed positive HIV test.

(b) Units are to report persons with confirmed positive HIV tests to Hospital Infection Control on the Florida Adult HIV/AIDS Confidential Case Report Form DH 2139 and Addendum (DH 2134), if needed (Attachment 9 ) within five (5) working days of positive test results.

(c) Units are to report persons who meet the case definition for AIDS (Attachment 10) to Hospital Infection Control on the Florida Adult HIV/AIDS Confidential Case
Report Form DH 2139 and Addendum (DH 2134), if needed, within five (5) working days of diagnosis.

(3) Periodic Reporting to Hospital Infection Control:

(a) the occurrence of any disease indicating underlying cellular immunodeficiency that occurs following the completion of Florida Adult HIV/AIDS Confidential Case Report Form DH 2139 and DH 2134 (if needed);

(b) any change in resident’s residence;
   1. transfer from one ward to another;
   2. transfer from one unit to another;
   3. release from hospital;
   4. escape or elopement from hospital.

(c) the Unit Daily Infection Control Report may be used for this reporting using appropriate coding (Florida State Hospital Operating Procedure 153-16, Surveillance Program for Reporting of Endemic Levels of Common Illnesses and Communicable Diseases).

(4) External Reporting Requirements:

(a) The Department of Health Laboratory Request for HIV Testing, Form 1628 (Attachment 11), when completed contains risk factors for HIV as well as other demographic information. The Department of Health will collect needed data from the Form 1628 which accompanies specimens sent to the Department of Health Bureau of Laboratory Services for processing.

(b) HIV positive residents and residents who are diagnosed as AIDS cases will be reported to the Gadsden County Health Department and/or the Department of Health Bureau of HIV/AIDS on Form DH 2139 and DH 2134 (if needed) by Hospital Infection Control within designated time frames in accordance with the confidential reporting procedures for communicable diseases required by Florida state law and regulations.

h. Monitoring and Reporting Requirements:

(1) Florida State Hospital has three (3) communicable disease monitoring groups: Civil Services, Forensic Services, and Staff Personnel. These monitoring groups, which shall include a Senior Physician, will be headed by the respective Assistant Hospital Administrators, with Hospital Legal Counsel, Hospital Clinical Director, Risk Manager, and Hospital Infection Control Nurses acting as consultants. One of the functions of these monitoring groups is to assist in making decisions regarding treatment and placement of residents with HIV/AIDS.

(2) Florida State Hospital Staff Development will be responsible for monitoring and reporting staff education. All staff training completed will be documented on a Staff Training and Information Reporting System (STAIRS) Form and, if the training was done by Unit Staff, furnished to Staff Development by the end of each month. Staff development will maintain a record of employees and dates of attendance at HIV/AIDS Educational Classes. The Department Of Health shall have authority to review the records of each facility to determine compliance.
(3) Individual Unit Directors/designee will be responsible for the direction of the resident HIV/AIDS education program in the respective units. All resident education will be documented on the Immunization/Treatment Record--Communicable Diseases/Education Form (Form 13). The Unit Level program will include a provision for entering resident education data into the Computer Information System by the last day of each month.

(4) Hospital Information Systems will furnish the Office of Quality Assessment and Planning--Infection Control all resident HIV/AIDS Education data at the beginning of each month.

(5) Quality Assessment and Planning--Infection Control will monitor the HIV counseling/testing program in conjunction with the Department of Health annually.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES
Hospital Administrator

11 Attachments

1. Consent Form Confidential Human Immunodeficiency Virus (HIV) Test (Department of Health Form 1818, page 1)
2. Model Protocol on Counseling and Testing for County Health Departments and Registered Testing Programs
3. Statement of Objection to HIV/AIDS Testing (Department of Health Form 3161)
4. Immunization/Treatment Record/Communicable Diseases/Education Form (Form 13)
5. Instruction Guide for HIV Testing/Counseling
6. Management of Occupational Blood Exposure to HBC, HCV or HIV
7. Resident/Employee Possible Blood/Body Fluid Exposure Report (Form 180)
8. HIV/AIDS Educational Standards for Residents
9. Florida Adult HIV/AIDS Confidential Case Report (Form DH 2139) and Addendum (DH 2134)
10. Case Definition for AIDS for Surveillance Purposes
11. HIV/AIDS Lab Request (Form 1628) and Instructions
SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL
This operating procedure has been revised to include the updated Florida Adult HIV/AIDS Confidential Case Report Form DH 2139.
HIV testing is a process that uses FDA-approved tests to detect the presence of HIV, the virus that causes AIDS and to see how HIV is affecting your body. The most common type of HIV test detects antibodies produced by the body after HIV infection. Test results are highly reliable but a negative test does not guarantee that you are healthy. Generally, it can take up to three months for HIV antibodies to develop. This is called the “window period.” During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive antibody HIV test means that you are infected with HIV and can also give it to others even when you feel healthy.

There are two other tests available that can help you and your doctor understand how HIV is affecting your body. The first measures how much virus is in your blood. This is known as a viral load test. The second measures the number of T-cells in your blood and is known as a CD4/CD8 test. Viral load and CD4/CD8 tests can only be ordered by a qualified medical provider.

If you consent by filling out and signing this form you will be asked for a blood or oral sample. Generally, test results will be available in about 2 weeks. If a rapid HIV test is used, results will be available the same day. If the rapid test detects HIV antibodies, it is very likely that you are infected with the virus, but this result will need to be confirmed. You will be asked to submit a second specimen for further testing. The results from this confirmatory test will be available to you in about 2 weeks.

If you test positive, the local health department will contact you to help with counseling, treatment, case management and other services if you need them and want them. You will be asked about sex and/or needle-sharing partners, and voluntary partner counseling and referral services (PCRS) will be offered to you. The HIV test result will become part of your confidential medical record. If you are pregnant, or become pregnant, the test results will become part of your baby's medical record.

If you test positive, we are requesting that you also allow your blood to be tested using the STARHS method. No additional blood is needed for STARHS. STARHS was developed to estimate what percentage of people testing positive acquired their infection during the past year. Learning how and where recent HIV transmission is happening will help us better understand the epidemic and how it affects our communities.

Finding HIV infection early can be important to your treatment, which along with proper precautions, helps prevent spread of the disease. If you are pregnant, there is treatment available to help prevent your baby from getting HIV. If you have any questions, please ask your counselor, physician, or call the Florida AIDS Hotline (1-800-FLA-AIDS or 1-800-392-2437) before signing this form.

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**CONSENT GIVEN**

Client must initial the consent statement and then sign below. The consent form must be dated and witnessed.

**REQUIRED**

______ YES ______ NO I have been informed about HIV testing and its benefits and limitations. I understand that some tests require a second specimen to be taken from me for further testing.

Initial Here

Date

Signature of Client or Legal Representative

Client’s Printed Name

Witness Signature

Legal Representative’s Relationship to the Client (If Applicable)

**OPTIONAL**

______ YES ______ NO If I move out of the area or live somewhere else, I want my results forwarded to the appropriate public health care provider or the physician listed below so that I may be informed of my results and receive post-test counseling.

Initial Here

If Applicable

Preferred Physician or Facility and their Mailing Address

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Instructions:
1. Please ensure that clients read and understand the information provided on this consent form. If clients are unable to read or understand this information, the counselor should read it to them.
2. The client must initial each of the three consent statements as appropriate and sign and date the bottom of the form.
3. If a legal representative of the client signs the consent form, their relationship to the client must be indicated on the appropriate line.
4. In accordance with state protocol, if the client wants their results forwarded, the STD Program Manager will handle this transaction.
5. All consent forms must have a witness signature. The counselor conducting the pre-test counseling can serve as the witness.
Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs

This model protocol provides guidelines on performing anonymous and confidential HIV counseling and testing in accordance with statutory requirements and established public health policy. Florida law carefully structures the manner in which health care providers may perform HIV tests. The law requires those who perform HIV tests in county health departments and other registered testing sites to obtain the informed consent of the test subject, make private counseling available both before and after the test and confirm positive preliminary results with a supplemental test before informing the test subject of the result.

Per guidelines from the Centers for Disease Control, the goal of HIV counseling and testing is to assist individuals in assessing their risk and understanding their test results and to help them develop a personalized prevention plan.

Evaluating an individual’s risk for HIV infection and offering HIV testing on a voluntary basis shall be a routine part of primary health care. Risk assessment should take place without regard to age, religion, sexual orientation, gender, race/ethnicity, marital status, economic status, social or other cultural factors.

1. Risk Assessment

Risk assessment involves asking the individual a series of open-ended questions to determine behaviors that may put them at risk for HIV infection. When conducting the risk assessment, it is important to assure the client that all information is confidential under Florida law. Questions should be asked in a professional, culturally sensitive, non-judgmental manner.

The following criteria should be used to help the test subject determine his or her level of risk:

- Sexual behavior
- Substance use/abuse
- Needle sharing
- Occupational exposure
- Blood/blood products/transplants
- Partners at risk for HIV
- History of sexually transmitted disease(s)
- Child of woman with HIV/AIDS
- History of sexual assault/domestic violence
- Sex for drugs/money

Appropriate referrals should be made based on information obtained in the risk assessment. The Florida Domestic Violence Hotline (1-800-500-1119) provides information and referrals in English, Spanish and Creole.

2. Pre-Test Counseling

Pre-test counseling shall include information on:

- Purpose of the HIV test;
- Indications for testing (medical indication and/or information obtained from the risk assessment);
- The possible need for retesting;
- Information on how to avoid contracting and transmitting HIV infection;
- Potential social, medical, and economic effects of a positive test result;
- Options for eliminating and/or reducing risk behavior;
- The availability of support services for those awaiting test results (e.g., hotlines, pre-test counselor's name and telephone number, county health department number); and,
- Scheduling a specific date for receiving test results.

Each test subject shall be made aware of the benefits, availability and confidentiality of locating and counseling sex or needle sharing partners. Each test subject shall also be made aware of the availability of county health department staff in assisting with partner notification. It is important to note that the county health department never reveals the identity of the test subject when notifying partners of possible exposure.

3. Informed Consent

- No person shall perform an HIV test without first obtaining the informed consent of the test subject or his or her legal representative. The limited exceptions to obtaining informed consent can be found in s. 381.004 (3)(h), Florida Statutes.

- When obtaining informed consent, explain the right to confidential treatment of information identifying the subject of the test and the results of the test to the extent provided by law. Persons with knowledge of an individual's HIV test result have legal obligations to protect this information from unauthorized disclosure. Florida law imposes strict penalties for breaches of confidentiality.

- In accordance with Administrative Rule 64D-2.004, Testing Requirements, an explanation of the following information represents a sound and reasonable standard for obtaining informed consent:
  a. An HIV test is a test to determine if an individual is infected with the virus which causes AIDS;
  b. The potential uses and limitations of the test (the reliability of the results and what positive, negative and indeterminate results do and do not mean);
  c. The procedures to be followed; and,
  d. HIV testing is voluntary and consent to be tested can be withdrawn at any time prior to testing.

- Persons who volunteer to be tested confidentially for HIV should be informed that positive test results will be reported to the local county health department so that health department staff may contact persons who test positive to offer follow-up activities. Examples of voluntary follow-up activities are post-test counseling for persons who do not return for test results, referrals for medical evaluation, case management services and voluntary partner notification. Persons who test positive anonymously should also be offered follow-up services. (Exemptions from HIV-reporting include persons tested anonymously at a registered anonymous test site, testing in the event of a significant exposure or university-based medical research protocols approved by the Department of Health.)

- The test subject must also be given information on the availability and location of anonymous test sites. Each county health department shall maintain a list of available anonymous test sites to be disseminated to all persons and programs offering HIV testing within their service area.
4. Post-Test Counseling

The person ordering the test or that person’s designee shall ensure that all reasonable efforts are made to notify the test subject of his or her test result. Post-test counseling should be offered to all test subjects and should be based on the test result and the individual’s needs as determined during the risk assessment. Post-test counseling shall include:

- The meaning of the test results;
- The potential social, medical and economic effects of a positive test result;
- The possible need for retesting;
- A reassessment of risk;
- Availability of health care, mental health, social and support services;

  Options for eliminating and/or reducing the transmission of HIV infection to the individual and/or partners. Florida law imposes strict penalties upon those who knowingly transmit HIV infection to others;

- If positive, a discussion of past and present sex and/or needle-sharing partners who may have been exposed to HIV and a plan on how to notify those partners. A good faith effort must be made to notify all spouses from the past ten years of their potential exposure;

- If positive, a discussion of the increased risk for TB and appropriate referrals for TB testing and treatment; and,

- Other appropriate referrals (e.g., STD, primary care, psychosocial).

5. Release of Preliminary HIV Test Results

Pursuant to s. 381.004(3)(d), Florida Statutes, preliminary test results may be released to health care providers and to the person tested when decisions about medical care or treatment cannot await the results of confirmatory testing. Positive preliminary HIV test results shall not be characterized to the patient as a diagnosis of HIV infection. Justification for the use of preliminary test results must be documented in the medical record by the health care provider who ordered the test. This does not authorize the release of preliminary test results for the purpose of routine identification of HIV-infected individuals or when HIV testing is incidental to the preliminary diagnosis or care of a patient. Corroborating or confirmatory testing must be conducted as follow up to a positive preliminary test. Results shall be communicated to the patient according to statute regardless of outcome.

6. Pregnant Women/Special Provisions (This requirement was effective October 1, 1996)

Florida law (s. 384.31, Florida Statutes) requires a health care provider who attends a pregnant woman for conditions relating to her pregnancy to offer testing for HIV and counsel her on the availability of treatment if she tests positive.

If the pregnant woman objects to HIV testing, a reasonable attempt must be made to obtain a written statement of objection, signed by the patient, which shall be placed in her medical record. (If a pregnant woman tests HIV negative, consideration should be given to offering the test again at a later date during her pregnancy because of the window period of up to 6 months between exposure to HIV and testing positive for antibodies and the risk of exposure during pregnancy through sex or needle sharing.)
Statement of Objection to HIV Testing

This section is to be used only for pregnant women who object to HIV testing.

Section 384.31, Florida Statues and Rule 64D-3.042, require that each health care provider and/or midwife attending a pregnant woman, notify a pregnant woman that she will be tested for HIV, syphilis, Chlamydia, gonorrhea, and hepatitis B unless she declines one or more of the tests.

I, ________________________________, have been notified that I will be tested for HIV, syphilis, Chlamydia, gonorrhea, and hepatitis B, and that I have the right to refuse any or all tests.

I decline the following test(s): (please initial) □ HIV □ syphilis
□ chlamydia □ gonorrhea
□ hepatitis B

_________________________________________  _______________________
Patient’s signature                  Date

_________________________________________
Witness

□ Patient refused to sign.

_________________________________________
Witness

________________________
Name: ________________________________
ID No.: ____________________________
Date of Birth: ________________________

DH 3161, 01/07
Obsoletes all previous editions
Which may not be used

Attachment 3
Operating Procedure 153-31
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<td>(Induration in mm)</td>
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<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovac Vaccine</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
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</tr>
<tr>
<td>Other (Specify)</td>
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<td></td>
</tr>
</tbody>
</table>

**COMMUNICABLE DISEASES (Enter Date Tested Positive/Treated and Initials)**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Date Tested Positive</th>
<th>Date Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis Active Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.I.V.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE & TITLE**

<table>
<thead>
<tr>
<th>SIGNATURE &amp; TITLE</th>
<th>INIT.</th>
<th>SIGNATURE &amp; TITLE</th>
<th>INIT.</th>
</tr>
</thead>
</table>

**INSTRUCTIONS:** Immunization/Treatment to be administered, and form completed by a Licensed Nurse. See FSHOP 150-58, "Immunization and Preventive/Active Treatment of Certain Communicable Diseases" and FSHOP 155-2, "Human Sexuality."

Form to be brought forward with each admission.

Form to be filed in Flow Sheet section of the ward chart.
### RESIDENT'S NAME & NUMBER

<table>
<thead>
<tr>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS/STD*</td>
<td>Sexual Conduct/Behavior*</td>
<td>Family Planning/Birth Control*</td>
<td>HIV Pre-Test Counseling</td>
<td>HIV Post-Test Counseling</td>
<td>Medication Education</td>
</tr>
<tr>
<td>Signature &amp; Title</td>
<td>INIT.</td>
<td>Signature &amp; Title</td>
<td>INIT.</td>
<td>Signature &amp; Title</td>
<td>INIT.</td>
</tr>
</tbody>
</table>

### EDUCATION

<table>
<thead>
<tr>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS/STD*</td>
<td>Sexual Conduct/Behavior*</td>
<td>Family Planning/Birth Control*</td>
<td>HIV Pre-Test Counseling</td>
<td>HIV Post-Test Counseling</td>
<td>Medication Education</td>
</tr>
<tr>
<td>Signature &amp; Title</td>
<td>INIT.</td>
<td>Signature &amp; Title</td>
<td>INIT.</td>
<td>Signature &amp; Title</td>
<td>INIT.</td>
</tr>
</tbody>
</table>

* Components of Human Sexuality Training (admission within 60 days and annually) in accordance with FSHOP 155-2, Human Sexuality. Initial and date when component complete. If education is offered and resident refuses, document in progress notes and re-offer education every thirty days. Date of completion, refusal, and or exclusion is input into the computer data base.

*** CONFIDENTIAL & PRIVILEGED INFORMATION *** FOR PROFESSIONAL USE ONLY ***

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Form 13, (Revised) Mar 01
FLORIDA STATE HOSPITAL
Attachment 4
COMMUNICABLE DISEASES/EDUCATION FORM
Page 2 of 2
Operating Procedure 153-31
GADSDEN
ATTEN: James E. Correll 90-485
Florida State Hospital
0.0. Box 1000
Palm Lane Bldg. 1230
Chattahoochee, Fl. 32324-1000

TEST SITE COPY

CONFIDENTIAL

A negative HIV-1 antibody test means only that
the person has no detectable antibodies to the
virus at the time of testing.

If lab results are not consistent with clinical
manifestations/risk factors, submit an [HIA] plasma
specimen. Report all positive results to
County Health Department.

Florida State Hospital
P.O. Box 210
Palm Lane Bldg. 1230
Chattahoochee, Fl. 32324-1000

Comments

Attachment 5
Page 1 of 4
Operating Procedure 153-31
<table>
<thead>
<tr>
<th>Test Name</th>
<th>Results</th>
<th>Flags</th>
<th>Reference Range</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV (HUMAN IMMUNODEF. VIRUS)</td>
<td>NEGATIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above test was performed by the Bureau of Labs/Dept. of Health/State Laboratory in Jacksonville, Fla.

Note: H indicates HIGH value  "H indicates critical HIGH value
L indicates LOW value   "L indicates critical LOW value
Purpose: These guidelines are designed to assist in the HIV Testing/Counseling and processing of all HIV orders. It is important to follow these guidelines set by the Department of Health and adopted by Florida State Hospital. You must be a certified HIV Counselor or licensed physician in order to provide the pre-test or post-test counseling.

Process:
The medical doctor/advanced registered nurse practitioner writes an order in the medical record for HIV testing; however, this order is not routine for all admissions. In addition, a separate order for HIV testing must be entered into the laboratory information system. Pre-test HIV counseling is a pre-requisite to all HIV orders.

A certified HIV Counselor must meet with the resident to complete the HIV Consent form (DH 1818) and DH Form 1628, to include documentation of all demographics, HIV history, and risk factors. The consent form remains in the medical record; the lab does not need a copy. Once this pre-test counseling is complete, an order gets placed in the laboratory information system. The completed DH Form 1628 must be provided to the laboratory technologist at the time of the collection; otherwise, the order will be cancelled.

Once the FSH Laboratory receives the results from the Department of Health State Laboratory, a “Results Packet” will be compiled. The lab will send the Unit Nurse Manager the “Results Packet”, document when the packet was sent out and to whom it was sent and forward this information to the Registered Nurse Consultant –Infection Control, in Quality Assessment and Planning. The “Results Packet” will consist of the three attached forms: pages 1 and 2 are carbon copies (labeled “Test Site Copy” and “Post-Test Documentation Form”, these are the official documents sent by the Department of Health) and the third page is the official FSH Clinical Lab Results page.

The Unit Nurse Manager will be responsible for distributing the “Results Packet” to a HIV Counselor, preferably the counselor who completed the pre-test counseling. The Nurse Manager will document on a tracking form which HIV Counselor the “Results Packet” was distributed to.

Once the HIV Counselor receives the “Results Packet”, the counselor must keep the carbon copied pages together and complete the required documentation. Please note that for the carbon copy to be visibly read the counselor must use a ball point pen on a firm, flat surface and bear down on the carbon copy in order for the carbon to copy. The boxed “Post Test Date” area must be bubbled in. The counselor must document his/her name.

The medical doctor may provide post-test counseling, but must follow the same procedure as the Certified HIV Counselor regarding documentation.

After completing the required post-test counseling documentation, the HIV Counselor should separate pages one and two of the carbon copies received from the Department of Health: page 1 labeled “Test Site Copy” and the FSH Clinical Lab Results page must remain in the official medical record. Page 2 of the carbon copy, labeled “HIV POST-TEST DOCUMENTATION FORM”, must be sent to the Registered Nurse Consultant - Infection Control in Quality Assessment and Planning within 10 days of departure of this “Results Packet” from the lab. Within 30 days the Registered Nurse Consultant – Infection Control must mail the HIV Post-test Documentation Form to the Department of Health, Bureau of HIV/AIDS, 4052 Bald Cypress Way, BIN A09, Tallahassee, FL 32399-1715.
Step 1. Provide immediate care to the exposure site:
- Wash Wounds and skin with soap and water
- Flush mucous membranes with water

Step 2. Evaluate the exposure:
Determine risk associated with exposure

<table>
<thead>
<tr>
<th>Exposures posing risk of infection transmission</th>
<th>Substances posing risk of infection transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percutaneous injury</td>
<td>• Blood</td>
</tr>
<tr>
<td>• Mucous membrane exposure</td>
<td>• Fluids containing visible blood</td>
</tr>
<tr>
<td>• Non-intact skin exposure</td>
<td>• Potentially infectious fluids (semen; vaginal secretions; and cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids) or tissue</td>
</tr>
<tr>
<td>• Bites resulting in blood exposure to either person involved.</td>
<td>• Concentrated virus</td>
</tr>
</tbody>
</table>

Step 3. Give postexposure prophylaxis (PEP) for Exposures posing risk of infection transmission:

- **HBV – see Table**
  - Give PEP as soon as possible, preferably within 24 hours
  - PEP can be given to pregnant women

- **HCV – PEP not recommended**

- **HIV – See Table**
  - Initiate PEP within hours of exposure
  - Offer pregnancy testing to all women of childbearing age not known to be pregnant.
  - Seek expert consultation if viral resistance suspected
  - Administer PEP for 4 weeks if tolerated.

Step 4. Perform follow-up testing and provide counseling:

- **HBV – exposures**
  - Test for anti-HBs 1-2 months after last dose of vaccine if only vaccine given
  - Follow-up not indicated if exposed person immune to HBV or received HBIG PEP

- **HCV – exposures**
  - Perform testing for anti-HCV and ALT 4-6 months after exposure
  - Perform HCV RNA testing at 4-6 weeks if earlier diagnosis of HCV infection desired.
  - Confirm repeatedly reactive anti-HCV EIA with supplemental tests.

- **HIV – exposures**
  - Evaluate exposed persons taking PEP within 72 hours after exposure and monitor for drug toxicity for at least 2 weeks.
  - Perform HIV-antibody testing for at least 6 months postexposure (e.g., at baseline, six weeks, 3 months and 6 months)
  - Perform HIV antibody testing for illness compatible with an acute retroviral syndrome
  - Advise exposed persons to use precautions to prevent secondary transmission during follow-up period
**Recommended HBV PEP**

<table>
<thead>
<tr>
<th>Vaccination and antibody response status of exposed worker*</th>
<th>Treatment when source is found to be:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HB† positive</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unvaccinated</strong></td>
<td>HBIG§ x 1 and initiate hepatitis B vaccine series.</td>
</tr>
<tr>
<td><strong>Previously vaccinated</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Known responder</strong></td>
<td>No treatment</td>
</tr>
<tr>
<td><strong>Known non-responder</strong></td>
<td>HBIG x 1 and initiate Re-vaccination or HBIG x 2**</td>
</tr>
</tbody>
</table>
| **Antibody response unknown**                            | Test exposed person for anti-HBs††  | No treatment | Test exposed for anti-HBs:  
1. If adequate, no treatment  
2. If inadequate, HBIG x 1 and vaccine booster |

* Persons who have previously been infected with HBV are immune to reinfection and do not require post-exposure prophylaxis.
† Hepatitis B surface antigen.
§ Hepatitis B immune globulin; dose 0.06 ml/kg intramuscularly.
¶ A responder is a person with adequate levels of serum antibody to ABsAg (i.e., anti-HBs ≥ 10 mlU/ml); a non-responder is a person with inadequate response to vaccination (i.e., serum anti-HBS < 10 mlU/ml).
** The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for non-responders who have not completed a second 3-dose vaccine series but failed to respond, 2 doses of HBIG are preferred. Give one dose at time of exposure, and the second dose one month later.
†† Antibody to HBsAg.
# Recommended HIV PEP

## Percutaneous injuries

<table>
<thead>
<tr>
<th>Exposure type</th>
<th>Infection status of the source</th>
<th>Source of unknown HIV status</th>
<th>Unknown source</th>
<th>HIV-negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV-positive, Class 1*</td>
<td>Asymptomatic HIV infection or known low viral load (e.g., &lt; 15,000)</td>
<td>Generally, no PEP†§ Warranted.</td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>HIV-positive, Class 2*</td>
<td>Symptomatic HIV Infection, AIDS, acute seroconversion, or known high viral load.</td>
<td>Generally, no PEP†§ Warranted.</td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>Source of unknown HIV status</td>
<td>(e.g. deceased source person with no samples available for HIV testing.)</td>
<td></td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>Unknown source</td>
<td>(e.g. a needle from a sharps disposal container)</td>
<td></td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>HIV-negative</td>
<td></td>
<td></td>
<td>No PEP warranted</td>
</tr>
</tbody>
</table>

### Less Severe

- (e.g., solid needle, superficial injury)
  - Recommend basic 2 – drug PEP
  - Recommend expanded 3 drug PEP
  - Generally, no PEP†§ Warranted.

### More Severe

- (e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein)
  - Recommend expanded 3 drug PEP
  - Recommend expanded 3 drug PEP
  - Generally, no PEP†§ Warranted.

## Mucous membrane exposures and non-intact skin exposures

<table>
<thead>
<tr>
<th>Exposure type</th>
<th>Infection status of the source</th>
<th>Source of unknown HIV status</th>
<th>Unknown source</th>
<th>HIV-negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV-positive, Class 1*</td>
<td>Asymptomatic HIV infection or known low viral load (e.g., &lt; 15,000)</td>
<td>Generally, no PEP†§ Warranted.</td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>HIV-positive, Class 2*</td>
<td>Symptomatic HIV Infection, AIDS, acute seroconversion, or known high viral load.</td>
<td>Generally, no PEP†§ Warranted.</td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>Source of unknown HIV status</td>
<td>(e.g. deceased source person with no samples available for HIV testing.)</td>
<td></td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>Unknown source</td>
<td>(e.g. splash from inappropriately disposed blood)</td>
<td></td>
<td>No PEP warranted</td>
</tr>
<tr>
<td></td>
<td>HIV-negative</td>
<td></td>
<td></td>
<td>No PEP warranted</td>
</tr>
</tbody>
</table>

### Small volume

- (e.g., few drops)
  - Consider basic 2-drug PEP†
  - Recommend basic 2 – drug PEP
  - Generally, no PEP†§ Warranted.

### Large volume

- (e.g., major blood splash)
  - Recommend basic 2 – drug PEP
  - Recommend expanded 3 drug PEP
  - Generally, no PEP†§ Warranted.

---

* If drug resistance is a concern, obtain expert consultation. Initiation of PEP should not be delayed pending expert consultation and because expert consultation alone cannot substitute for fact-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

† The designation, “consider PEP,” indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician. However, consider basic 2-drug PEP for a source with HIV risk factors, or occurs in a setting where exposure to HIV-infected persons is likely.

§ If PEP is offered and taken, and the source is later determined to be HIV negative, PEP should be discontinued.

¶ For skin exposures, follow-up is indicated only if there is evidence of compromised skin integrity (e.g., dermatitis, abrasion, or open wound).
RESIDENT/EMPLOYEE POSSIBLE BLOOD/BODY FLUID EXPOSURE REPORT

SECTION I: (COMPLETED BY UNIT/DEPARTMENT)

DATE: ___________  TIME: ___________  UNIT/DEPARTMENT: ___________________________________  WARD/POD: ___________

TYPE OF EXPOSURE:  Bite _________   Needle Stick _________  Open Wound _________  Mucous membrane/mouth _________
Mucous membrane/eyes_________  Sexual contact_________  Other (specify)_______________________

DESCRIPTION OF EXPOSURE: _______________________________________________________________________________
_______________________________________________________________________________

PREVIOUS HEPATITIS/HIV STATUS OF PERSON RECEIVING EXPOSURE:

Name and Hospital Number: ___________________________________________________________________________________

History of Hepatitis: Yes _________   No _________  History of HIV: Yes _________   No _________
 Tested for Hepatitis: Yes _________   No _________  Tested for HIV: Yes _________   No _________
 If Yes, Date/Results: ____________________________  If Yes, Date/Results: ____________________________
 Rec’d HBIG: Yes _________   No _________ 
 Rec’d HB Vaccine: Yes _________   No _________  Date Hep B vaccine Completed: ____________________________
 Tested for Antibodies: Yes _________   No _________
 Date/Results: ___________________________________________________________________________________

PREVIOUS HEPATITIS/HIV STATUS OF PERSON CAUSING EXPOSURE:

Name and Hospital Number: ___________________________________________________________________________________

History of Hepatitis: Yes _________   No _________  History of HIV: Yes _________   No _________
 Tested for Hepatitis: Yes _________   No _________  Tested for HIV: Yes _________   No _________
 If Yes, Date/Results: ____________________________  If Yes, Date/Results: ____________________________
 Rec’d HBIG: Yes _________   No _________
 Rec’d HB Vaccine: Yes _________   No _________  Date Hep B vaccine Completed: ____________________________
 Tested for Antibodies: Yes _________   No _________
 Date/Results: ___________________________________________________________________________________

SIGNATURE/PERSON COMPLETING SECTION I          DATE
*******************************************************************************************************************

SECTION II: (COMPLETED BY UNIT/DEPARTMENT FOR RESIDENT EXPOSURE; SUPERVISOR FOR EMPLOYEE EXPOSURES)

TYPE TESTING/TREATMENT ORDERED ________________________________________________________________________
___________________________________________________________________________________________________________

SIGNATURE/PERSON COMPLETING SECTION II         DATE
*******************************************************************************************************************

SECTION III: (COMPLETED BY HOSPITAL INFECTION CONTROL NURSE)

REPORT OF HOSPITAL INFECTION CONTROL NURSE ____________________________________________________________
___________________________________________________________________________________________________________

SIGNATURE/Person COMPLETING SECTION III        DATE
*******************************************************************************************************************

INSTRUCTIONS:

SECTION I: Completed by Unit/Department.  If employee exposure, the employee should personally write the “Description of Exposure,” if resident exposure, the nurse or supervisor should complete the “Description of Exposure.”

SECTION II: Completed by Unit Department if resident exposure; Supervisor if employee exposure.

SECTION III: Completed by the Hospital Infection Control Nurse.

GENERAL: Sections I and II are to be completed as soon as possible after exposure occurs.  All completed forms are to be forwarded to the Office of Quality Assessment and Planning/Hospital Infection Control and Office of Risk Management within forty-eight (48) hours.
I. BASICS OF TRANSMISSION

a. Seriousness of the disease.

b. Sexual modes of transmission:
   - penis/vagina
   - penis/rectum
   - mouth/rectum
   - mouth/genitals

c. Non-sexual modes of transmission:
   - Sharing needles or ‘works as in use of intravenous drugs
   - Perinatally from mother to child
   - blood/blood products

d. A single exposure of any kind may result in infection.

e. An individual can be infected with the AIDS virus without having symptoms or appearing ill. Infected individuals with or without symptoms can transmit the virus to others. Once infected, a person is presumed infected for life, even though symptoms may not develop for several years.

f. The virus is not spread by the following:
   - Casual contacts such as handshakes, hugs, doorknob, and toilet seats (there is no reason to avoid an infected person in ordinary personal and professional contact)
   - Giving blood
   - Mutually monogamous/exclusive sexual relationships, assuming neither partner is infected, nor becomes infected via non-sexual modes of transmission.

II. PREVENTION

a. Abstinence from sex or having a mutually monogamous relationship with an uninfected person is the best ways to avoid infection with the AIDS virus.

b. If not abstaining from sexual activities and partner’s HIV antibody status is positive or unknown, then:
   - Practice “safe sex” which mean choosing sexual partners carefully and using barrier protection (condoms); use of a spermicide that kills viruses, in addition to using a condom, is recommended.
   - Condoms and spermicides reduce the risk of infection with the virus that causes AIDS; they may not be 100% effective in preventing transmission of the virus.
   - Encourage partners, at risk for HIV infection, to seek HIV antibody counseling and testing services.
   - Reduce number of sex partners.
   - Avoid prostitutes.
c. Do not use IV drugs; do not share needles or “work.”

d. Females, known to be at risk/infected, should avoid pregnancy.

e. Use caution in sharing personal items which have the potential to be contaminated with blood:
   - do not share tooth brushes or razors;
   - do not share pierced earrings.

III. INFECTION CONTROL

a. Caregivers are in charge of clean-ups for spills of any body fluids. Residents should notify staff of spills.

b. Caregivers are in charge of caring for injured clients. Residents should not treat each other’s cuts, nosebleed, etc.

c. Sanitary napkins and similar items should be disposed of in plastic bags.

d. Blood-soaked gauze and similar items should be disposed of in red plastic bags for incineration.

e. If residents perform housekeeping tasks, gloves should be worn when cleaning bathrooms. Hands should be washed with soap and water after gloves are removed.

f. Blood contaminated items for laundry should be handled with gloves and may be laundered per routine using hot water and detergent.

g. Gloves should be worn whenever handling any materials with blood or body fluids.

h. Good personal hygiene should be stressed, including hand washing with soap and water.
# Florida Adult HIV/AIDS Confidential Case Report

(Patients = 13 years of age at time of diagnosis)

## I. HEALTH DEPT USE ONLY

<table>
<thead>
<tr>
<th>Document Source</th>
<th>New Investigation</th>
<th>Report Medium</th>
<th>Surveillance Method</th>
<th>State Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes no</td>
<td>PV F M PF ET DK</td>
<td>A F P R U</td>
<td></td>
</tr>
</tbody>
</table>

Report Status Update: Rptg. CHD City/Co: Date form completed: / / 

## II. PATIENT IDENTIFIER INFORMATION—data not transmitted to CDC

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>SS#:</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>County</td>
</tr>
<tr>
<td>State</td>
<td>Zip</td>
<td>Phone ()</td>
</tr>
<tr>
<td>City/County</td>
<td>Zip</td>
<td></td>
</tr>
</tbody>
</table>

## III. DEMOGRAPHIC INFORMATION—complete ALL fields

<table>
<thead>
<tr>
<th>Diagnostic Status:</th>
<th>Sex at Birth:</th>
<th>Date of Birth:</th>
<th>Country of Birth:</th>
<th>Status:</th>
<th>Death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity (select one): Hispanic, Not Hispanic or Latino, Unknown

Race (select all that apply): Black/AA, Asian, Native American or Alaskan, White, Hawaiian/PI, Unk

Residence at Diagnosis: Same as Current

Street Address:

City:

State/Country:

Zip:

## IV. FACILITY OF DIAGNOSIS

Facility Name:

Address:

City:

State/Country:

Zip:

Facility Type (check one):

- Physician, HMO
- Hospital, Inpatient
- Other

Facility Code:

Facility Serving (check one):

- Public
- Private
- Other

Provider Name:

Provider Ph. No.: ()

Med. Rec. No.:

Person Completing Form:

Phone No.:

## V. PATIENT HISTORY—complete ALL fields

### VI. LABORATORY DATA

<table>
<thead>
<tr>
<th>HIV Antibody Tests at Diagnosis (Date mm/dd/yyyy)</th>
<th>HIV Detection Tests: (Record earliest mm/dd/yyyy)</th>
<th>Positive</th>
<th>Negative</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-1 EIA</td>
<td>HIV-1 NAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-1/2 EIA</td>
<td>HIV-1 Qual PCR RNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-1 Western Blot/IFA</td>
<td>HIV-1 P24 Antigen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>HIV-1 Qual PCR DNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Virus Load Test: (most recent mm/dd/yyyy)</th>
<th>Immunologic Lab Test: (Test date mm/dd/yyyy)</th>
<th>Type Name</th>
<th>Copies / ML</th>
<th>Collection Date</th>
<th>At or closest to current diagnosis status</th>
<th>Collection Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-1 NASBA</td>
<td>CD4:4 Count %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-1 RT-PCR</td>
<td>First&lt;200 or &lt;14% of total lymphocytes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-1 bDNA</td>
<td>CD4:4 Count %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Physician Diagnosis:</th>
</tr>
</thead>
</table>

If HIV laboratory test were not documented, is HIV diagnosis documented by a physician? Yes No Unk

If yes, enter date of diagnosis (mm/dd/yyyy): DH 2139, 7/39

Attachment 9
Page 1 of 4
Operating Procedure 153-31
### VII. CLINICAL STATUS

<table>
<thead>
<tr>
<th>Clinical Record Reviewed?</th>
<th>Initial Dx Date</th>
<th>Def.</th>
<th>Initial Dx Date</th>
<th>Def.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Candidiasis, bronchi, trachea, or lungs</td>
<td>□ Lymphoma, Burkitt's (or equivalent term)</td>
<td></td>
<td>□ Lymphoma, Burkitt's (or equivalent term)</td>
<td></td>
</tr>
<tr>
<td>Candidiasis, esophageal</td>
<td>□ Lymphoma, immunoblastic (or equivalent terms)</td>
<td></td>
<td>□ Lymphoma, immunoblastic (or equivalent terms)</td>
<td></td>
</tr>
<tr>
<td>Carcinoma, invasive cervical</td>
<td>□ Lymphoma, primary in brain</td>
<td></td>
<td>□ Lymphoma, primary in brain</td>
<td></td>
</tr>
<tr>
<td>Coccidioidomycosis, disseminated or extrapulmonary</td>
<td>□ Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary</td>
<td></td>
<td>□ Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary</td>
<td></td>
</tr>
<tr>
<td>Cryptococcosis, extrapulmonary</td>
<td>□ Mycobacterium, other species or unidentified species, disseminated or extrapulmonary</td>
<td></td>
<td>□ Mycobacterium, other species or unidentified species, disseminated or extrapulmonary</td>
<td></td>
</tr>
<tr>
<td>Cryptosporidiosis, chronic intestinal (&gt;1 mo. duration)</td>
<td>□ Pneumocystis carinii pneumonia</td>
<td></td>
<td>□ Pneumocystis carinii pneumonia</td>
<td></td>
</tr>
<tr>
<td>Cytomegalovirus disease (other than in liver, spleen, or nodes)</td>
<td>□ Pneumonia, recurrent, in 12 mo. period</td>
<td></td>
<td>□ Pneumonia, recurrent, in 12 mo. period</td>
<td></td>
</tr>
<tr>
<td>Cytomegalovirus retinitis (loss of vision)</td>
<td>□ Progressive multifocal leucoencephalopathy</td>
<td></td>
<td>□ Progressive multifocal leucoencephalopathy</td>
<td></td>
</tr>
<tr>
<td>HIV encephalopathy</td>
<td>□ Salmonella septicemia, recurrent</td>
<td></td>
<td>□ Salmonella septicemia, recurrent</td>
<td></td>
</tr>
<tr>
<td>Herpes simplex: chronic ulcer(s) (&gt;1 mo. duration); or bronchi, pneumonitis or esophagitis</td>
<td>□ Toxoplasmosis of brain</td>
<td></td>
<td>□ Toxoplasmosis of brain</td>
<td></td>
</tr>
<tr>
<td>Histoplasmosis, disseminated, or extrapulmonary</td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
</tr>
<tr>
<td>Isosporiasis, chronic intestinal (&gt;1 mo. duration)</td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
</tr>
<tr>
<td>Kaposi's sarcoma</td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
<td>□ Wasting syndrome due to HIV</td>
<td></td>
</tr>
</tbody>
</table>

**Def. = definitive diagnosis  Pres. = presumptive diagnosis**

### VIII. TREATMENT/SERVICES REFERRALS

**Patient informed of his/her infection?** □ Yes □ No □ Unk

This patient's partner will be notified about their HIV exposure and counseled by: □ 1-Health Dept. □ 2-Physician □ 3-Patient □ 9-Unk

**Is patient receiving or been referred for:**

<table>
<thead>
<tr>
<th>HIV related medical services?</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Antibody testing?</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No □ Unk</td>
<td>□ Yes □ No □ Unk</td>
<td></td>
<td></td>
<td>□ Yes □ No □ Unk</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Substance Abuse treatment services?** □ Yes □ No □ Unk

**Is patient enrolled in a clinical trial?** □ 1-NIH-sponsored □ 2-Other □ 3-None □ 9-Unknown

**This patient has been enrolled at (Clinic):**

**At the time of HIV/AIDS diagnosis, medical treatment is primarily reimbursed by:** □ Medicaid □ Pri. Ins/HMO □ Other

### WOMEN ONLY

**Is patient receiving or been referred for obstetrical or gynecological services?** □ Yes □ No □ Unk

**Is patient currently pregnant?** □ Yes □ No □ Unk

**Has patient delivered a live-born infant?** □ Yes □ No □ Unk

### CHILDREN OF PATIENT

**Date of Birth:**

**Child's Name:**

**Child's Surname:**

**Child's State No.:**

### IX. LOCAL FIELDS

<table>
<thead>
<tr>
<th>PRISM #</th>
<th>NIR/status: NIR/OP</th>
<th>NIR/OP DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC #</td>
<td>NIR_CL</td>
<td>NIR CL DATE:</td>
</tr>
<tr>
<td>CONTACT STATION(s):</td>
<td>NIR_RE</td>
<td>NIR RE DATE:</td>
</tr>
<tr>
<td>OTHER RISKS: A_ B_ C_ D_ F_ M_ V_ J_</td>
<td>INITIALS</td>
<td>SOURCE CODE A_</td>
</tr>
</tbody>
</table>

**HEPATITIS: A_ B_ C_ Other Unknown**

### X. COMMENTS:

---

Sample
ADDENDUM FOR ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥ 13 years of age at time of diagnosis)

Date Form Completed:
__/__/____
(Day) (Month) (Year)

XII. PREVIOUS TESTING HISTORY

Has the patient had a prior test for HIV?
(If no or unknown, skip to section XIII)
☐ Yes  ☐ No  ☐ Unknown

First Positive HIV Test
List the month and year of the patient's first positive HIV test ____/____ (month) (year)
(state where first positive HIV test was performed)
In the two years prior to the patient's first positive test, list the total number of times the patient tested for HIV ______ (do not include the patient's first positive test in this count)

Last Negative HIV Test
Has the patient ever tested negative for HIV?
☐ Yes  ☐ No  ☐ Unknown
List the month and year of the patient's last negative HIV test ____/____ (month) (year)

XIII. ANTIRETROVIRAL (ARV) MEDICATIONS

Ever taken any ARV drugs?
☐ Yes  ☐ No  ☐ Unknown

First day of ARV medication ____/____ (month) (year)
(99/9999 = unknown)

Last day of ARV medication ____/____ (month) (year)
(99/9999 = unknown)  ☐ Patient is currently taking any ARV

Code of ARV medication(s)
(see reverse side for codes)

DH 2134.12/06  (Stock number 5744-000-2134-9)
Directions for Completing Form

XI. State/Local Use only
Indicate patient's last name, first name and middle initial. Include the patient's current address and phone number, county of residence, state of residence and zip code. Patient identifying and locating information is not sent to CDC. List the date the form was completed.

XII. Previous Testing History
If the patient has never been tested for HIV before this test, skip to Section XIII. If the patient has been tested previously for HIV, indicate the month and year of the patient's first test for HIV, regardless of results. If unknown, indicate the value 99/9999. If month or year is known, state the known value (i.e., 99/2000).

First Positive HIV Test
All of the questions in this section reference the patient's first positive HIV test ever. List the month and year of the patient's first positive test for HIV. If unknown, indicate the value 99/9999. If month or year is known, state the known value (i.e., 99/2000). Indicate the state where the first positive HIV test was performed. Indicate the total number of tests the patient had during the two years prior to receiving their first positive result (do not include the first positive test result in this count).

Last Negative Test
Indicate whether the patient has ever had a negative HIV test prior to receiving their first positive results. If no or unknown, skip to Section XIII. If the patient has had a previous negative HIV test, list the month and year of the most recent negative test. If unknown, indicate the value 99/9999. If month or year is known, state the known value (i.e., 99/2000).

XIII. Antiretroviral Medications
Indicate whether the patient has ever taken antiretroviral medications. If yes, indicate the month and year the patient first began taking ARV medications. List the month and year the patient stopped taking ARV medications. Check the box if the client is currently taking ARV. If unknown, indicate the value 99/9999. If month or year is known, state the known value (i.e., 99/2000). List the names of the medications taken by the client using the abbreviation list below.

<table>
<thead>
<tr>
<th>Medicine Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protease Inhibitors</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Agenerase 01</td>
</tr>
<tr>
<td>Crixivan 03</td>
</tr>
<tr>
<td>Fortovase 06</td>
</tr>
<tr>
<td>Invirase 09</td>
</tr>
<tr>
<td>Kaletra 10</td>
</tr>
<tr>
<td>Lexiva 21</td>
</tr>
<tr>
<td>Norvir 11</td>
</tr>
<tr>
<td>Reyataz 14</td>
</tr>
<tr>
<td>Viracept 19</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

DH 2134,12/06 (Stock number 5744-000-2134-9)

Attachment 9
Page 4 of 4
Operating Procedure 153-31
CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

1993 EXPANSION FOR ADULTS AND ADOLESCENTS

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the listed “indicator” diseases, depending on the status of laboratory evidence of HIV infection. The following information is excerpted from MMWR, Vol. 41, No. RR-17, December 18, 1992, “1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults.”

APPENDIX B. Conditions Included in the 1993 AIDS Surveillance Case Definition

- HIV positive person with CD4 cell counts < 200/ul or a CD4 percent < 14% *
- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive *
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (greater than 1 month's duration)
- Kaposi’s sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary, of brain
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary
- Mycobacterium tuberculosis, any site (pulmonary * or extrapulmonary)
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent *
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

*Added in the 1993 expansion of the AIDS surveillance case definition.
## Rapid Test Use Only

**Previous Positive Use Only**

### To be completed for clients who have previously tested positive

- **Date of First Positive Test**
- **Date of Last Negative Test**

### Prevent HIV

- **Risk Factors**
  - **Sexual Activity**
  - **Injection Drug Use**
  - **Mycobacterium Tuberculosis (Beijing)**
  - **Other Risk Factors**

### Hepatitis History

- **A**
- **B**
- **C**

### Laboratory Information

- **Additional Laboratory Information**
- **Test Date**
- **Test Time**
- **Test Site**
- **Test Result**
- **Test Repetition**

### Client Information

- **First Name**
- **Last Name**
- **DOB**
- **SSN**
- **Address**
- **Telephone**
- **Next of Kin**

### Consent

- **Consent Given**
- **Consent Date**

### Consent Form

- **Form Number**
- **Form Title**
- **Date**
- **Signed by**

### Additional Information

- **Referral Source**
- **Referral Number**
- **Referral Date**
- **Referral Reason**

### Confidentiality

- **Name of Client**
- **Address**
- **Telephone**
- **Social Security Number**

### Pre-Test Counseling

- **Date**
- **Time**
- **Counselor**
- **Referral**

### Post-Test Counseling

- **Date**
- **Time**
- **Counselor**
- **Referral**
Antiretroviral (ARV) Questions and Medicine Codes: These questions must be asked of all clients. Some clients may be taking ARV and not have an HIV positive test result, e.g., post-exposure prophylaxis, hepatitis B treatment or for some other reason. If the client says yes, ask them which ones they have taken. Identify the medication taken and record the applicable code on the front of the form. The medication codes are listed below.

<table>
<thead>
<tr>
<th>Medicine Codes</th>
<th>15 Sustiva</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Agenerase</td>
<td>16 Trizivir</td>
</tr>
<tr>
<td>02 Combivir</td>
<td>17 Truvada</td>
</tr>
<tr>
<td>03 Crizalane</td>
<td>18 Videx</td>
</tr>
<tr>
<td>04 Entriva</td>
<td>19 Videx EC</td>
</tr>
<tr>
<td>05 Eplvir</td>
<td>20 Vinacept</td>
</tr>
<tr>
<td>06 Fortovase</td>
<td>21 Viremune</td>
</tr>
<tr>
<td>07 Fuzeon</td>
<td>22 Viread</td>
</tr>
<tr>
<td>08 Hivid</td>
<td>23 Zerit</td>
</tr>
<tr>
<td>09 Invirase</td>
<td>24 Ziajen</td>
</tr>
<tr>
<td>10 Kaletra</td>
<td>25 Zerit XR</td>
</tr>
<tr>
<td>11 Norvir</td>
<td>26 Lexiva</td>
</tr>
<tr>
<td>12 Rescriptor</td>
<td>27 Epizont</td>
</tr>
<tr>
<td>13 Retrovir</td>
<td>28 Hepsera</td>
</tr>
<tr>
<td>14 Reyataz</td>
<td>00 New Drug Not Listed</td>
</tr>
</tbody>
</table>

Important Reminder for Rapid Test Sites:
✓ Complete the RAPID TEST USE ONLY section of the form in its entirety including the “Client Given Result” and “Rapid Test Result” fields.
✓ When sending the DH1628 to the lab for confirmation of a reactive rapid test, always indicate the type of confirmatory specimen being sent and mark the “RAPID TEST REACTIVE” box at the top of the form.
✓ DO NOT mark the specimen type or “RAPID TEST REACTIVE” boxes at the top of the DH1628 for Non-Reactors tests.
✓ In accordance with DH rules, completed GOLD (top) copy forms showing a NON-REACTIVE rapid test, and the reactive rapid TEST ID FORM that are sent to the bureau must be double enveloped, with the inner envelope clearly marked “CONFIDENTIAL” and sent to the bureau via traceable DHL, UPS, Federal Express (or other similar carrier) within one month of testing to:

Bureau of HIV/AIDS
2585 Merchant’s Row Blvd.
Tallahassee, FL 32399
Attention: Rapid Testing Data/Room 335

✓ Do not send any logs other than the reactive rapid test ID FORM to the bureau. All other logs must be maintained at the test site.
Instructions for Form 1628 HIV Lab Request

Please complete numbered blanks with indicated information

1) Site Address: Florida State Hospital, Bldg. 1238, Palm Lane, Chattahoochee, Fla. 32324-1000

2) Site Number 10-210

3) Local Use : Put Resident number

4) Counselor Number – Put first initial, last name of HIV Counselor

5) Pretest Counsel Date: _______________ and consent signed yes with date.
   NOTE: Lab tests for HIV ARE NOT to be entered into the Laboratory Computer
   (CLINILAB) until pretest counseling and consent date are obtained. The Lab will NOT
draw blood if the pretest counseling date and the consent signed date with yes is not
completed.

6) Check type of test to be done. Put an X in block 1 for blood.

7) Resident’s last name, first name, MI.

8) Phone – Home Unit Main Number with area code.

9) Address: Florida State Hospital, P.O. Box 1000, Chattahoochee, Fla. 32324-1000

10) Date of Birth:

11) SS#: 

12) Unit Number and Ward

13) Medicaid Number (if pt. has one)

Complete all sections as completely as possible.

Units – make a copy of the lab request for the resident’s medical record. Place the copy with
the informed consent under the Legal Section of the medical record.

The entire Lab request goes to the Lab with the specimen.

Label lab tube with resident’s full name, medical record #, collector’s initials, date and time.

Documentation-Pre and post test HIV Counseling is to be documented in the Nursing Progress
Note and the Immunization Record (Form 13), page 2, Education section

7/30/2008